City of Rochester *Effective January 1, 2016*

2016 Benefit Options

The table below outlines covered services. Family limits apply to two or more covered lives per employee/subscriber.

	Base Plan	HDHP with HSA
1. Annual Deductible		
	$200 per person; $400 per family	$3,000 per person; $6,000 per family
2. Annual Out-of-Pocket Limit		
Medical services and prescription drugs	$3,000 per person; $6,000 per family	$3,000 per person; $6,000 per family
3. Ambulance		
	80/20% after deductible	100% after deductible
4. Chiropractic Services – Note: 25 visit limit per person per year.		
This plan uses the HSM Chiropractic Network	80/20% after deductible	100% after deductible
5. Durable Medical Equipment – Prior authorization from the plan is required for items over $750.		
Prosthetics, orthotics and disposable supplies	80/20% after deductible	100% after deductible
6. Emergency Services and Urgent Care Services		
a. Emergency room	80/20% after deductible	100% after deductible
b. Inpatient emergency hospital physician services	80/20% after deductible	100% after deductible
c. Urgent care services	80/20% after deductible	100% after deductible
d. Convenience clinics	100%	100% after deductible
7. Home Health Care – Prior authorization required.		
	80/20% after deductible	100% after deductible
8. Hospice Care – Prior authorization required – lifetime limit of $10,000.		
	80/20% after deductible	100% after deductible
9. Inpatient and Outpatient Hospital and Physician Services		
a. Physician and related services (except preventive care)	80/20% after deductible	100% after deductible
b. Inpatient hospital services	80/20% after deductible	100% after deductible
c. Outpatient hospital, ambulatory care or surgical facility services	80/20% after deductible	100% after deductible
10. Maternity		
a. Prenatal care services – per schedule attached	100%	100%
b. Delivery and inpatient hospitalization	80/20% after deductible	100% after deductible

	Base Plan	HDHP with HSA
11. Mental Health and Chemical Dependency Services		
a. Outpatient	80/20% after deductible	100% after deductible
b. Inpatient	80/20% after deductible	100% after deductible
12. Outpatient Diagnostic Tests		
a. MRI, CT and PET scans	80/20% after deductible	100% after deductible
b. Other diagnostic tests	80/20% after deductible	100% after deductible
13. Outpatient Prescription Drugs		
a. Prescription drugs including Diabetic supplies purchased at a Retail Pharmacy (up to 34-day supply)	Generic: $10 co-pay Brand: $20 co-pay or 20% co-insurance, whichever is greater	100% after deductible
b. Prescription drugs including Diabetic supplies purchased through Mayo Clinic Mail Order Pharmacy (up to 102-day supply)	80/20%	100% after deductible
14. Preventive Care – Applies to all covered services.		
a. Routine physical exams	100%	100%
b. Other preventive care services covered as listed on the Preventive Care Schedule on the next page	100%	100%
c. Annual vision exam	100%	100%
d. Annual routine hearing exam	100%	100%
15. Rehabilitation Services – Certain prior authorization requirements apply.		
a. Physical therapy	80/20% after deductible	100% after deductible
b. Speech therapy	80/20% after deductible	100% after deductible
c. Occupational therapy	80/20% after deductible	100% after deductible
d. Cardiac rehabilitation	80/20% after deductible	100% after deductible
16. Skilled Nursing Facility – Prior authorization required.		
	80/20% after deductible	100% after deductible
17. Transplants – Prior authorization required.		
	80/20% after deductible	100% after deductible
18. Lifetime Maximum Benefit		
	Unlimited	Unlimited

Note: Prior authorization is required for some services. Refer to your Summary Benefit Description for details. Out-of-network services are subject to usual and customary charges.

The City of Rochester Medical Benefit Plans are administered by Mayo Clinic Health Solutions, a subsidiary of Mayo Clinic, operating under contract to City of Rochester; if there are any inconsistencies between this document and the Summary Benefit Description, the Summary Benefit Description will be relied upon for plan administration. If you have any questions about the plans, please contact Mayo Clinic Health Solutions Customer Service toll-free at 1-800-771-9215 (TDD 1-800-407-2442).

Preventive Care Services	AGES

Covered preventive care services are limited to once per member per coverage year unless otherwise indicated.

All Members	> 5	≥ 11	≥ 12	≥ 18	≥ 19	≥ 20	≥ 45	≥ 50	≥ 55	≥ 60	≥ 75	> 80
Hepatitis C (HCV) screening for people at high risk for infection and one-time screening for people born between 1945 and 1965	X	X	X	X	X	X	X	X	X	X	X	X
Obesity screening and counseling	X	X	X	X	X	X	X	X	X	X	X	X
Chlamydia, gonorrhea and syphilis screening		X	X	X	X	X	X	X	X	X	X	X
High intensity behavioral counseling to prevent sexually transmitted diseases		X	X	X	X	X	X	X	X	X	X	X
Human immunodeficiency virus (HIV) screening		X	X	X	X	X	X	X	X	X	X	X
Human papillomavirus (HPV) screening – once every 3 years		X	X	X	X	X	X	X	X	X	X	X
Depression screening			X	X	X	X	X	X	X	X	X	X
Diabetes screening				X	X	X	X	X	X	X	X	X
High blood pressure screening				X	X	X	X	X	X	X	X	X
Alcohol misuse screening and counseling					X	X	X	X	X	X	X	X
Healthy diet for hyperlipidemia/risk for diet related chronic disease counseling					X	X	X	X	X	X	X	X
Tobacco use counseling					X	X	X	X	X	X	X	X
Lipid panel once every 5 years						X	X	X	X	X	X	X
Glucose screening once every 3 years							X	X	X	X	X	X
Colorectal cancer screening options (one of the following): • Fecal occult blood test (series of three) with flexible sigmoidoscopy every 5 years • Barium enema and flexible sigmoidoscopy every 5 years • CT Colonography every 5 years • Colonoscopy once every 10 years					X	X	X	X	X	X	X	X
Lung cancer screening with history of smoking					X	X	X	X	X	X	X	
Herpes zoster/shingles vaccine one time only								X	X	X	X	X

Children's Health	**Birth**	2	3	5	6	7	9	10	11	12	18	19	20	21
Expanded newborn screen (blood)	X													
Phenylketonuria (PKU) once at birth	X													
Evoked otoacoustic emissions (EOAE) once at birth	X													
Prophylactic eye medication for gonorrhea once at birth	X													
Congenital hypothyroidism screening – one time only between birth and 1 year	X													
Sickle cell disease screening – one time only between birth and 1 year	X													
Iron supplements – between 6-12 months	X													
Autism screening	X	X												
Developmental screening – up to four screenings between birth and 36 months	X	X	X											
Psychosocial/Behavioral assessment – up to four assessments between birth and 36 months	X	X	X											
Pediatric vision screening	X	X	X	X										
Dental caries chemoprevention, oral fluoride	X	X	X	X	X									
Lead level screening	X	X	X	X	X									
Human Immunodeficiency virus (HIV) screening if at increased risk	X	X	X	X	X	X	X	X						
Tuberculin skin testing (TB)	X	X	X	X	X	X	X	X	X	X	X			
Hepatitis C virus (HCV) screening for members at high risk	X	X	X	X	X	X	X	X	X	X	X			
Developmental surveillance	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hematocrit or Hemoglobin screening	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Metabolic/Hemoglobin	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lipid panel		X	X	X	X	X	X	X	X	X	X	X		
Alcohol and Drug use assessment									X	X	X	X	X	X

Preventive Care Services , continued	AGES

Covered preventive care services are limited to once per member per coverage year unless otherwise indicated.

Men's Health	**≥ 18**	**≥ 45**	≥ 65	> 75	≥ 80
Vasectomy sterilization procedure	X	X	X	X	X
Aspirin to prevent Cardiovascular Disease (CVD)		X	X	X	
Abdominal Aneurysm screening – one time only			X		

Women's Health	**≥ 9**	**≥ 11**	≥ 19	≥ 21	> 26	≥ 40	≥ 45	≥ 55	≥ 80
Human papillomavirus (HPV) vaccine	X	X	X	X	X				
FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity		X	X	X	X	X	X	X	X
Breast cancer chemoprevention counseling			X	X	X	X	X	X	X
Counseling and testing related to BRCA with family history			X	X	X	X	X	X	X
Papanicolaou smear (once every 3 years age 40-65)				X	X	X	X	X	X
Mammogram						X	X	X	X
Breast cancer screening			X	X	X	X	X	X	X
Osteoporosis screening – one time only ages 45-59; then once per coverage year							X	X	X
Aspirin to prevent Cardiovascular Disease (CVD)								X	

Preconception and Prenatal Care
Folic acid supplements for members planning or capable of pregnancy
Bacteriuria screening for pregnant female – once per pregnancy
Hepatitis B screening for pregnant female – once per pregnancy
HIV screening for pregnant female
Iron deficiency screening for pregnant female
RH Incompatibility screening for pregnant female – twice per pregnancy
Syphilis screening for pregnant female
Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and costs for breastfeeding equipment
Gestational diabetes screening for high risk pregnant female between 24 and 28 weeks of gestation and at the first prenatal visit

Immunizations – *Frequency and specific age guidelines based on Advisory Committee on Immunization Practices*	**≤ 6**	≥ 7	≥ 19
Diphtheria, Tetanus, Pertussis (Tdap)	X	X	X
Hepatitis A	X	X	X
Hepatitis B	X	X	X
Influenza	X	X	X
Measles, Mumps, Rubella (MMR)	X	X	X
Meningococcal	X	X	X
Pneumococcal	X	X	X
Inactivated Poliovirus (IPV)	X	X	
Rotavirus	X		
Haenophilus Influenza Type B	X		
Human papillomavirus (HPV)		X	X
Varicella		X	X